STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	03/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY VILLAGE NURSING HOME	3518 S SHELBY ST INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/25/13 Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Bethany Village Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 0101 was surveyed using Chapter 19, Existing Health Care Occupancies. This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0101 was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	155237	A. BUILDING 01 B. WING	03/25/2013

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	alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 87 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for one detached storage shed. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/28/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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	155237	A. BUILDING 01 B. WING	03/25/2013

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K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	Based on observation and interview, the facility failed to ensure 2 of 2 openings through the ceiling in the mechanical room in the laundry into the attic were maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any staff or visitor in the vicinity of the mechanical room in the laundry. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:05 p.m. on 03/25/13, the following was noted in the mechanical room in the laundry: a. an "L" shaped opening in the ceiling measuring four inches long by three inches wide through which two water lines passed into the attic was not firestopped. b. the annular space surrounding a one	K010025	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The two openings through the ceiling in the mechanical room in the laundry into the attic were repaired and firestopped on 4/11/13 by maintenance staff. A building review was completed on 4/11/13 with no further concerns in smoke barriers identified. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. The two openings through the ceiling in the mechanical room in the laundry into the attic were repaired and firestopped on 4/11/13 by maintenance staff. A building review was completed on 4/11/13 with no further concerns in smoke	04/23/2013

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	inch water line which penetrates the ceiling into the attic was not firestopped. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned locations in the mechanical room in the laundry were not firestopped. 3.1-19(b)		barriers identified. What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? When repairs or building damages occurs in the future, facility will review areas to ensure these areas are maintained to provide at least one half hour fire resistance rating. Another building review will be conducted by 4/23/13 to ensure smoke barriers are being maintained to provide at least a one half hour fire resistance rating. An inservice for all staff will by completed by 4/23/13 to educate staff on awareness of smoke barriers. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter to ensure smoke barriers are constructed and maintained to provide at least a one half hour fire resistance rating. The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	

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K010044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 1 fire barrier walls was maintained to provide a two hour fire resistance rating. LSC 7.2.4.3.1 requires fire barriers separating building areas where there are horizontal exits shall have a 2 hour fire resistance rating and shall provide a separation that is continuous to ground. This deficient practice could affect 26 residents, staff and visitors near the Activities Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:05 p.m. on 03/25/13, a two hour rated fire barrier is in the attic above the corridor doors by the Activities Room. One layer of the four layers of five-eighths inch thick drywall of the attic fire barrier wall had a four inch in diameter hole in the layer which was not firestopped to maintain the two hour fire rating of the fire barrier. The drywall layer which had the opening was on the north side of the wall. Based on interview at the time of observation, the Maintenance Director acknowledged the hole in the aforementioned attic fire barrier wall did not maintain the two hour	K010044	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The drywall of the attic fire barrier wall was repaired and firestopped on 4/5/13 to ensure the two hour fire rating of the fire barrier. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. The drywall of the attic fire barrier wall was repaired and firestopped on 4/5/13 to ensure the two hour fire rating of the fire barrier. A building review was completed on 4/11/13 with no further concerns in smoke and fire barriers identified. What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? When repairs or building damages occurs in the future, facility will review areas to ensure these areas are maintained to provide a two hour fire rating of the fire barriers. Another building review will be conducted by 4/23/13 to ensure fire barriers are being maintained to provide at least a two hour fire rating of the	04/23/2013

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	fire rating of fire barrier wall. 3.1-19(b)		fire barriers. An inservice for all staff will by completed by 4/23/13 to educate staff on awareness of smoke and fire barriers. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter to ensure fire barriers are constructed and maintained to provide at a two hour fire rating of the barriers . The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	

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K010056 SS=A	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to install an automatic sprinkler system in 1 of 1 Maintenance Office areas in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems. NFPA 13, Section 5-6.3.4, Minimum Distance Between Sprinklers, states sprinklers shall be spaced not less than six feet (72 inches) on center. This deficient practice could affect two staff and visitors in the vicinity of the Maintenance Office. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:05 p.m. on 03/25/13, two of the three sprinklers in the Maintenance Office were installed	K010056	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The sprinklers in the Maintenance office are to be repaired by 4/19/13 so that they are at least six feet apart. A building review was completed on 4/11/13 with no further concerns in spacing of sprinklers. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Residents currently living in the facility, visitors, and staff in the vicinity of the Maintenance office have the potential to be affected by the alleged deficient practice. The sprinklers in the Maintenance office are to be repaired by 4/19/13 so that they are at least six feet apart. A building review was completed on 4/11/13	04/23/2013

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	four feet apart from one another on the same sprinkler pipe protruding from the corridor wall into the room. Based on interview at the time of observation, the Maintenance Director acknowledged two of three sprinklers installed in the Maintenance Office were installed less than six feet apart from one another. 3.1-19(b)		with no further concerns in spacing of sprinklers. What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? When repairs, building damages, or building modifications occurs in the future, facility will review areas to ensure that sprinklers on automatic sprinkler system are spaced no less than six feet apart. Another building review will be conducted by 4/23/13 to ensure the repair of the sprinklers in the Maintenance office was completed and spaced at least 6 feet apart. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter to ensure sprinklers are spaced no less than six feet apart. The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	

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K010062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2-3.3 requires waterflow alarm devices including, but not limited to mechanical water gongs, vane type waterflow switches and pressure switches which provide audible or visual signals shall be tested quarterly. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on a review of P.I.P.E. "Report of Inspection" documentation dated 09/25/12 with the Maintenance Director during record review from 9:10 a.m. to 10:40 a.m. on 03/25/13, documentation of	K010062	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The sprinkler system inspection report dated 12/27/12 was received on 4/5/13 and placed in Maintenance records for future review. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. The sprinkler system inspection report dated 12/27/12 was received on 4/5/13 and placed in Maintenance records for future review. First quarter 2013 sprinkler system inspection was completed on 3/28/13 and is being maintained in Maintenance records for further review.What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? Sprinkler system inspections will be conducted quarterly. Sprinkler system reports will be kept in Maintenance Supervisor office. A Life Safety audit tool for sprinkler system inspections	04/23/2013

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	the fourth quarter 2012 (October, November, December) sprinkler system inspection was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fourth quarter 2012 sprinkler system inspection was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:05 p.m. on 03/25/13, a fourth quarter 2012 quarterly sprinkler inspection date was not written on the hanging tag P.I.P.E. had affixed to the sprinkler system riser to document quarterly sprinkler inspections. 3.1-19(b)		will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter to ensure the requirement is met for quarterly sprinkler inspections and records maintained and available for review. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter to ensure the requirement is met for quarterly sprinkler inspections and records maintained and available for review. The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	

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K020000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/25/13 Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Bethany Village Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 0202 consisting of the Therapy Room was surveyed using Chapter 18, New Health Care Occupancies. Building 0202 constructed in 2012 was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all	K020000		

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	areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 87 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for one detached storage shed.			